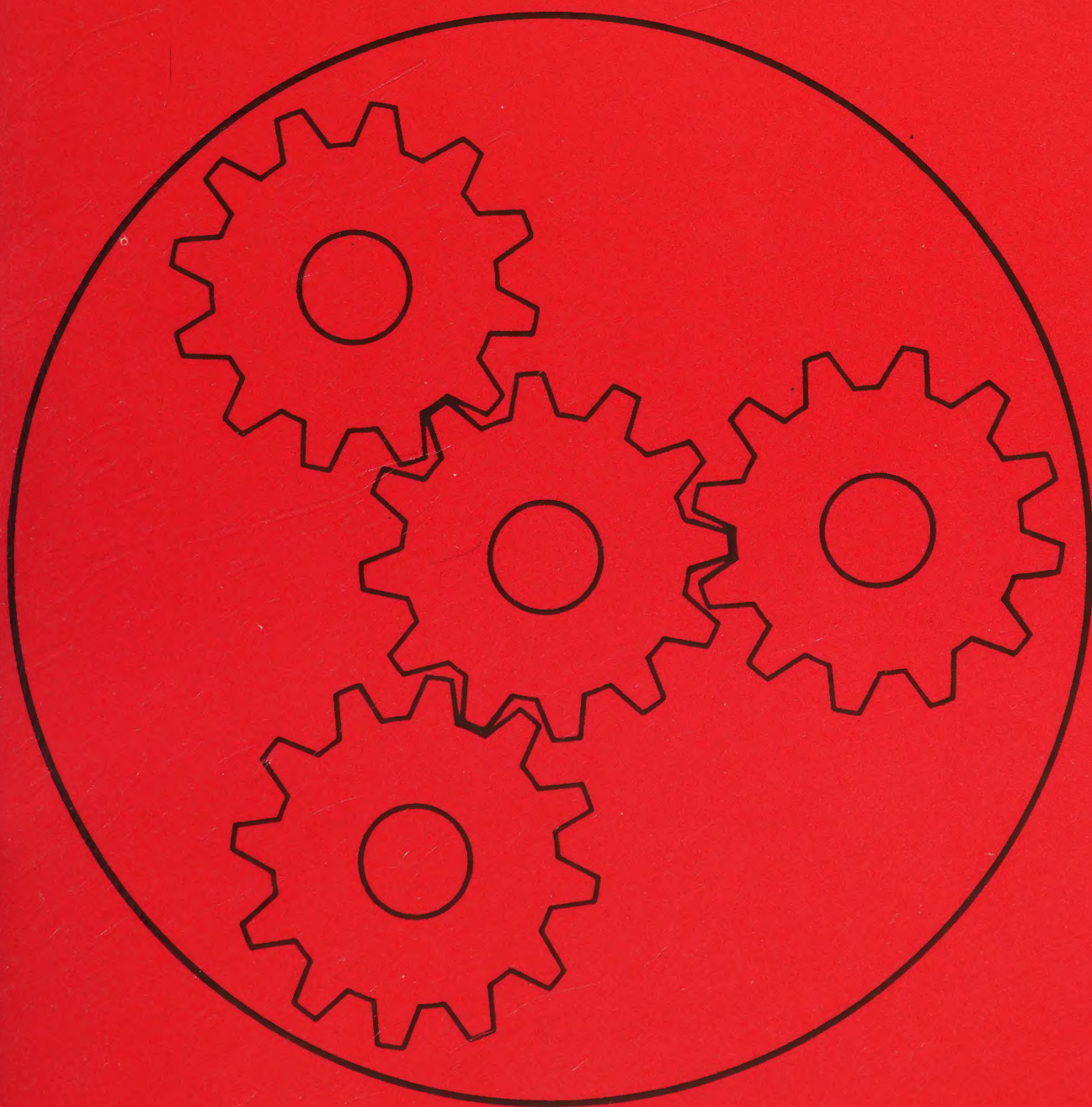


Third Report of
the Joint Working
Party on the
**Organisation of
Medical Work
in Hospitals**





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DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Published for the Department of Health and Social Security
on behalf of the Joint Working Party

Third Report of the Joint Working Party on the

Organisation of Medical Work in Hospitals

LONDON

HER MAJESTY'S STATIONERY OFFICE

1974

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Published by the Department of Health and Social Security
on behalf of the Joint Working Party

Final Report of the Joint Working Party on the

Organisation of Medical Work in Hospitals

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ISBN 0 11 320538 4

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FOREWORD

The Joint Working Party on the Organisation of Medical Work in Hospitals in England and Wales

The Working Party was reconstituted at the end of 1972 with largely new membership but with the great advantage of continuity in its secretariat. It did not take formal evidence from witnesses but obtained much information from within the hospital service and interviewed various individuals, some of whom prepared papers on the problems of particular departments in hospitals and of particular services. We are indebted to many who have provided written information and particularly to Dr T. Airie, Dr W. Edgar and Professor T. Oppé who also came to discuss certain aspects with us. Miss Phyllis Friend, Chief Nursing Officer at the Department of Health and Social Security, attended some meetings of the Working Party to advise on nursing aspects. We exchanged papers with a parallel Working Party on General Practice and there were two members common to both Working Parties. We wish to record our grateful thanks to Dr Ian Field, Mr Peter Fletcher and Dr Gillian Ford who have once more been the Working Party's invaluable secretariat and made possible the completion of our work in so short a time.

A symposium on information services, organised by Miss Goldsmith and Dr Mason, chaired by Dr Beddard, and attended by other members of the Working Party, gave an opportunity to discuss a variety of methods of evaluation which had been used effectively by the Cogwheel organisation in different hospitals. The proceedings of this symposium have been prepared for separate publication and this report therefore discusses the subject in less detail than would otherwise have been necessary.

The Working Party was particularly concerned with the clarification of relations between the Cogwheel organisation, which is now almost generally adopted in hospital groups, and the administrative system and its medical advisory machinery to be introduced in 1974. Chapter 2 is largely concerned with this and it is hoped that this can be made available to hospital medical staff and others concerned soon.

The views expressed in the report are those we put forward as individuals and do not purport to represent the views or policies of our sponsors. The Working Party believes that, although its present membership should now disband, the method of work is useful and should be continued.

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January 1974

1 INTRODUCTION

The third Cogwheel report

1. The terms of reference of the Working Party are:

“To consider what developments in the hospital service are desirable in order to promote improved efficiency in the organisation of medical work.”

2. The first Cogwheel report* proposed changes designed to improve the organisation, and therefore the overall quality, of medical work in hospitals. The second Cogwheel report† gave an account of progress in adopting and developing the new arrangements, described the elements which experience had shown were indispensable to an effective Cogwheel system, and provided examples of Cogwheel in action. The recommendations in these reports have been widely adopted and—as the record shows—have led in many cases to improvements in the organisation and quality of hospital medical care.

3. In producing this third Cogwheel report, the Working Party has had two main aims in view:

- i. to provide some clarification of the role of Cogwheel in the reorganised health service; and
- ii. to discuss advances in the fields of reviewing the quality of medical care and disseminating good practice, and to encourage further development of these activities through the Cogwheel machinery and in other ways.

The Working Party has concentrated on these particular subjects because further development of the Cogwheel machinery and its more effective use are both needed at the present time. But we have also looked at some further aspects of Cogwheel where we thought that discussion of practical difficulties encountered would be helpful. These include the organisation of medical work in specialties which serve a larger population than that of the district in which they are based, Cogwheel in undergraduate teaching hospitals, and information services for Cogwheel.

4. This report—like its forerunners—is founded on the experience of many doctors and their colleagues. The Working Party is convinced that changes based on the approach of the first and second Cogwheel reports have led to more efficient organisation and have helped hospital medical staff‡ to improve the effectiveness of medical care. We hope and believe that the proposals in this report, summarised below, will further assist these developments and help Cogwheel systems to adapt to the changing circumstances of health service reorganisation.

5. The Working Party recommends to the Secretary of State for Social Services and the Secretary of State for Wales, and to the Joint Consultants Committee,

* Ministry of Health. *First report of the Joint Working Party on the organisation of medical work in hospitals*. H.M.S.O. 1967.

† Department of Health and Social Security. *Second report of the Joint Working Party on the organisation of medical work in hospitals*. H.M.S.O. 1972.

‡ References to hospital medical staff throughout this report should be taken to include hospital dental staff.

that this third report should be published and made widely available. We also recommend that the proceedings of the symposium on information services for Cogwheel which the Working Party sponsored should be published separately, in the edited version prepared for us, and drawn to the attention of those who provide and use medical information services in hospitals.*

Main conclusions and recommendations

6. The new machinery for multi-professional management and planning will rightly be separate from the Cogwheel system, but this in no way diminishes the need for effective Cogwheel organisation in future (paragraph 29).

7. The respective roles of Cogwheel divisions and multi-disciplinary teams for planning and managing health services are illustrated by reference to services for some particular health care groups (paragraphs 30 to 42).

8. The decision whether small specialties with strong links outside the hospital (such as paediatrics and geriatrics) should form separate divisions is best made in the local situation. The advantages of doing so are uncertain (paragraphs 34 and 36).

9. Membership of divisions should include consultant and other permanent medical staff, non-medical scientists of equivalent standing, and senior registrars, in relevant specialities; representatives of other junior medical staff; and representatives from other divisions, as necessary. Membership of the medical executive committee should include a representative of junior medical staff. The appropriate administrator, nursing officer and community physician, and a spokesman for general practitioners, should have a standing invitation to attend and participate in divisional and medical executive committee meetings. Other professional or hospital scientific or technical staff should be invited to send representatives when appropriate (paragraphs 44, 45 and 52).

10. The Working Party welcomes the introduction of the district medical committee, which should contribute to mutual understanding of problems among doctors working in different parts of the health service and to a more effective medical contribution in the planning and management of health services (paragraph 49).

11. The district medical committee and medical executive committee have distinct and complementary parts to play in the reorganised health service. The medical executive committee is needed to co-ordinate the organisation of medical work in hospitals and should deal directly with the district management team on such matters; and the district medical committee is needed to bring a truly integrated approach to wider aspects of medical care (paragraphs 50 and 51).

* See footnote on page 38.

12. The district medical committee should consider inviting the district administrator, district nursing officer, or others to attend particular discussions if this seems appropriate (paragraph 53).

13. Multi-professional management arrangements can and should develop in a variety of ways. Existing arrangements which have proved their worth and have taken much time and effort to develop should be preserved and integrated with new machinery designed to meet new administrative needs. The way particular matters are settled should depend on how the best decisions can be reached with the most economical use of time by those involved (paragraph 54).

14. Consultants who give up some clinical work to devote more time to administration should be given an undertaking that their full clinical facilities will be restored when they relinquish the extra administrative work. Consultants who do not formally surrender clinical responsibilities should be given whatever clinical support is possible; for example, by redeployment of junior medical staff or increase of clinical assistant help (paragraph 56).

15. Doctors can conserve time while participating in management arrangements on a broad front by sharing jobs widely among themselves and being prepared to work through representatives. Examples are given of how administrative work may be shared. Doctors are more likely to allow spokesmen the freedom of action necessary to make multi-professional planning and management work successfully if methods of choosing spokesmen command the confidence of medical staff concerned (paragraphs 57 to 59).

16. Clinicians need suitable supporting services in their administrative work, both as members of divisions or committees reviewing the services they provide and as representative doctors in multi-professional teams. Administrative work falling on the clinical members of the district management team will be eased if they have a close working relationship with the district administrator and the district community physician (paragraphs 60 to 62).

17. Doctors are not expressly required to carry out detailed appraisal of the quality of their work, the outcome of surgical intervention, or the need for particular investigation in various clinical situations; or to compare the outcome of treatment in different places. Nevertheless, an increasing literature shows that there is growing recognition in medicine of the need for regular reviews by means which allow comparisons to be made (paragraph 68).

18. Medical executive committees and divisions should initiate local reviews of clinical events where pooling of information seems desirable (for example, anaesthetic deaths or mishaps, adverse drug reaction). They could also plan clinical work in a prospective and systematic way, so that a broad and general clinical policy can be established for the hospitals of a district and continually reviewed to achieve improvement (paragraphs 69 to 71).

19. Some regions have established visiting teams to look at care provided for particular groups of patients, such as the elderly and the mentally ill and handicapped. The use of such teams—composed of those involved in providing services—could spread to some acute specialties where services need to be planned and developed in the light of local circumstances and with the assistance of people with particular specialist knowledge (paragraph 81).

20. Clinical freedom of the individual doctor in his investigation or treatment of his patient—a principle on which the profession rightly sets great store—should be interpreted in the context of today. It must vary according to whether a clinician is practising as an individual or as a member of a team with complex and shared resources. Standard patterns of treatment or investigation should not be imposed but, in particular situations, an individual clinician may need to have regard to the collective view of his colleagues, expressed through the Cogwheel machinery or in other ways (paragraphs 82 to 85).

21. Medical work in specialties which serve a larger population than the district in which they are based (“supra-district specialties”) needs to be organised at two levels. At district level the specialty should form part of the Cogwheel system, where problems which arise locally will be tackled. There should also be some organisation of the specialty related to the population it serves. This should form a sub-committee of the area of regional medical advisory committee, and function as a “division” in relation to matters that require review at a level above that of the district (paragraphs 87 to 92).

22. Undergraduate teaching hospitals experience particular difficulties in establishing an effective Cogwheel system. Various arrangements have been adopted in an attempt to reconcile the competing claims of democracy and effectiveness. There is no “best” method, but whatever arrangements are adopted should be accompanied by good communication of decisions and policy, and lead to the development of an effective and well-informed medical executive committee (paragraphs 93 to 97).

23. District general hospitals, including undergraduate teaching hospitals with full district responsibilities, are natural focal points for post-graduate medical education and should all have postgraduate medical institutes (paragraph 98).

24. Junior medical staff should be given the opportunity to play a full part, through representatives, in the Cogwheel system and reasonable arrangements they make to secure this (for example, deputising schemes) should be accepted by divisions and medical executive committees (paragraph 99).

25. The successful tackling of problems in divisions and medical executive committees depends on a clear commitment by medical staff to seek and apply solutions, and on the availability of suitable administrative support. A practical approach—defining problems and applying relevant information to their analysis and solution—is the one most likely to achieve results (paragraphs 100 to 103).

2. COGWHEEL IN THE REORGANISED NATIONAL HEALTH SERVICE

26. The Cogwheel system evolved within one of the three separate parts of the National Health Service to meet the need for improved machinery through which hospital based doctors can co-ordinate their work among themselves and with others, and review services they provide including their use of resources. In the reorganised National Health Service the new administrative structure and the emphasis on multi-disciplinary management will present the health care professions with new and wider opportunities to develop an integrated approach. A fresh look at the Cogwheel principles and their practical application in the new context is needed.

27. Lines of communication between the hospital and its managing Authority will be extended in the reorganised health service. This is because separate hospital authorities will disappear and the new Area Health Authorities will have a wider range of responsibilities and will individually administer larger numbers of hospitals. Within each health district services will be planned and managed by multi-disciplinary teams in which representative clinicians will come together with administrative, nursing and other medical colleagues. These developments need not markedly increase overall the amount of administrative work done by clinicians but they will call for some redistribution of effort. It will be even more important in future to guard against any unnecessary overlap of machinery or duplication of activity, so that time of clinicians may be put to the best use. Clinicians will need to consider carefully how the limited time available for administrative matters can be best spent, and look closely at what they should do or decide themselves and what they should pass or leave to others. The reorganised health service will present hospital doctors with many opportunities to participate in the management of services. If these opportunities are to be used effectively, administrative work will have to be shared and representative arrangements, already well advanced in the Cogwheel system, will need to be further developed.

28. Bringing together all health services under a single Area Health Authority, with boundaries that match geographically those of the local authorities, should result in better arrangements for planning and managing health services and for co-ordinating them with relevant local authority services. Even before reorganisation there has been a variety of arrangements for securing co-ordination and collaboration. For example, many hospital groups have a "management team" in which senior administrative, medical and nursing colleagues come together to provide top level co-ordination. In the field of psychiatric services, it is becoming common for "therapeutic teams" composed of doctors, nurses, social workers, and other professional staff to provide hospital and domiciliary services for patients living in a defined area; and in some psychiatric hospitals multi-disciplinary teams of senior staff have been established to plan and manage the hospital's services and co-ordinate these

with services provided by local authorities. Sometimes the Cogwheel machinery provides a focal point for multi-disciplinary management. For instance, medical executive committees with strong administrative and nursing representation have been given wide ranging responsibilities in some places, and have come to play a central part in the management arrangements for their group of hospitals. Similarly, some Cogwheel divisions have adopted a multi-disciplinary approach to the organisation, management and planning of services. These and other developments have anticipated the parts to be played by new mechanisms in the reorganised health service. Experience of operating these arrangements will prove invaluable when new teams for managing and planning services on an integrated and multi-professional basis are established outside the Cogwheel structure.

29. This new machinery will rightly be separate from the Cogwheel system, which is hospital based and has predominantly medical membership. This separation in no way diminishes the need for effective Cogwheel organisation in future. But clinicians and other senior officers will need to participate fully in the new management and planning arrangements and should meet there on equal terms. There are two areas in which clarification may be helpful: the respective roles of multi-disciplinary teams (for management and planning) and Cogwheel divisions; and of the medical executive committee, district medical committee and district management team.

Multi-disciplinary management and planning teams and Cogwheel divisions

30. The Area Health Authority will exercise its responsibility for planning and managing health services through district management teams* which will be advised by health care planning teams on the needs of particular groups in the population of its district and how these needs may best be met in local circumstances. The concept of the health care planning team is applicable to identifiable groups of people requiring particular types of health care ("health care groups") for whom services are provided in alternative or complementary ways. Such teams will not cover all health care services and it is likely that they will be established initially for the elderly, children, the mentally handicapped and the mentally ill. A truly multi-disciplinary approach is required in planning services for these groups of people, linking health service with other agencies providing relevant services. The medical profession will be represented on the teams by hospital based doctors working in the particular field, by general practitioners, and by community physicians. If they are to work effectively, the planning teams must be small. To this end hospital based doctors in each clinical specialty involved will usually be represented by a single colleague.

* The district management team will include a consultant member and a general practitioner member, chosen by their colleagues, together with the district community physician, district nursing officer, district finance officer and district administrator. In areas that are not divided into districts there will be an area management team, composed in the same way.

31. In contrast, the Cogwheel division is primarily concerned with medical aspects of hospital care and offers participation to all hospital based doctors concerned with its field of activity. Members of other professions attend as appropriate but the division is essentially a forum for hospital based doctors*. It enables them to co-ordinate their work among themselves and with others, review the service they provide, reach joint decisions when necessary, and choose colleagues to represent them on the medical executive committee and on other bodies inside and outside the hospital with which the division needs to work in concert. In short, the Cogwheel divisional-executive system enables hospital based doctors to plan and develop their own work and, through spokesmen, to participate with other professions in planning and managing services on a wider basis. The respective roles of the Cogwheel system and multi-disciplinary teams for planning and managing services may be illustrated by reference to services for some particular health care groups.

Child Health Services

32. The following suggestions have been made in a paper on medical services for children prepared at our request. We support the underlying aims, but the particular proposals do not sufficiently reflect the need for multi-professional machinery separate from the Cogwheel system.

“An integrated child health service requires an organisation which can act as (a) a main source of comprehensive medical advice, (b) machinery by which the resources of the service can be effectively utilised and co-ordinated, (c) a means by which special facilities for children can be obtained, (d) a method for the examination and review of the provision of services and utilisation of resources, (e) a system which ensures that the service does not become isolated from the major disciplines of medicine, surgery and obstetrics . . . The most satisfactory way of fulfilling these objectives would be the establishment, within the Cogwheel structure, of children’s divisions or divisions of child health services. Such a division would represent all the medical specialties and other professions concerned with the provision of preventive and therapeutic health care to children, and using common facilities . . . Medical work for children in hospitals must be so organised that all aspects of the child’s stay or attendance are related to his continuing needs and past experiences. Thus it is of special importance that the children’s division should have wide representation.”

Health services for children should certainly be fully integrated, but we do not agree that the Cogwheel system is best placed to provide the necessary machinery for the multi-professional approach that is required.

33. The passage quoted above suggests that provision would be made within the Cogwheel structure for (i) planning and (ii) delivery on an integrated and multi-disciplinary basis of child health services, and for (iii) co-ordination of the work of all hospital doctors who provide services for children—including

* And, in relevant specialties, non-medical scientists of equivalent standing. (See paragraph 44 below.)

some mainly concerned with providing hospital services for adults. Co-ordinating the work of hospital based doctors who provide services to children or who use common facilities is predominantly a matter for doctors themselves, in which all concerned should participate, but responsibility for planning and co-ordinating delivery of services—as the quoted extracts make clear—is one that hospital based doctors share with others. A single piece of machinery within the Cogwheel system to provide for these different, although inter-related, functions would be unwieldy and may run the risk, or at least give the impression, that integrated planning of services would be medically dominated. Hospital based doctors who provide services for children as only a small part of their work may not wish to be personally involved in the integrated planning arrangements, whilst some professional people outside the hospital may not feel they can help with problems of co-ordination within the hospital. Where arrangements such as those described have already been established, the Cogwheel system has filled a void left hitherto by the tripartite organisation of health services, and the absence of clear-cut multi-professional arrangements for co-ordination within the health service and with local authorities. In this way it has pioneered new machinery for integrated and multi-disciplinary planning and management. When the new management arrangements for the reorganised National Health Service come into effect, responsibility for planning will pass to the health care planning team for children's services and responsibility for co-ordinating delivery of services to multi-disciplinary management teams that will be established at district level and below. This will leave the Cogwheel system free to concentrate on organising the work of hospital based doctors who provide services for children, and relating this work to the use of resources available to hospital services as a whole. Part of this responsibility will, of course, be to send representatives to planning and management teams and through these representatives to link the work of hospital based doctors with that of other senior staff concerned with providing services for children.

34. At present the number of separate paediatric divisions in Cogwheel systems is very small and we do not know how many of these divisions bring together *all* hospital based doctors who provide services for children. The advantages of having a separate paediatric or children's division are uncertain. Such a division would, of course, be well placed to focus on hospital services for children and link hospital based doctors to the multi-disciplinary teams that will plan or run services within the district. But there are also advantages in bringing paediatrics within the larger division of general medicine as in most cases at present, or linking it with obstetrics and gynaecology as sometimes occurs, provided there are adequate cross-divisional links with divisions covering other related specialties. The organisation of medical work for children in hospitals should ensure a comprehensive and co-ordinated service and continuity of care, but particular divisional arrangements designed to bring this about are best decided in the local situation.

Geriatric Services

35. Services for the elderly require good collaborative arrangements between hospital based doctors and people providing services outside the hospital—including general practitioners, community physicians, domiciliary nurses, social workers—as well as effective organisation of medical work within the hospital. Planning, and to a large extent management, of services needs to be on an integrated and multi-disciplinary basis. The author of a paper which we commissioned on psycho-geriatric services put forward the view that “advances in the care of old people are likely for the foreseeable future to derive from better organisation and evaluation of services rather than from purely clinical developments”. There is no doubt that unified health service administration and more effective collaboration between health and local authorities (which should be easier with matching areas), present new opportunities for improvement of services for old people.

36. Only a few Cogwheel systems have separate divisions of geriatric medicine, and no particular instance has been drawn to our attention of such a division as the main focal point for collaboration between all those concerned—within the hospital and outside it—in providing health services for the elderly. This job is being done increasingly by geriatric liaison committees which provide a forum for face to face contact and debate for senior staff concerned with health and social services for the elderly (for example, spokesmen for physicians in geriatric medicine, psychiatrists, general practitioners, local authority health and social services, hospital and local authority nursing services, and hospital administration). These liaison committees review the operation of services, and in some measure assess and monitor performance and need, and draw up plans. Suitably adapted, it should not be difficult to convert them into health care planning teams under the aegis of the district management team.

37. The role of Cogwheel is to provide an organisation capable of resolving problems that arise within the hospital and identifying areas in which improved medical services for old people in hospital are needed. This calls for effective collaboration and joint discussion of problems between geriatricians and hospital based doctors in other specialties who provide services for old people, particularly psychiatry, orthopaedics and general medicine. A separate division of geriatric medicine with appropriate cross-representation is one way of achieving this, but this option has not been widely adopted. No doubt, this is because the number of hospital based doctors involved is usually small (one or two geriatricians together with representatives of other divisions), and because of the advantages to a small and developing specialty—in the more typical arrangements—of being part of a larger division (general medicine) with a more powerful voice. Of course, a large general division has many competing claims on its resources, and the voice of geriatric medicine within it will usually be quite small in relation to the numbers of patients and staff involved. Whatever arrangements appear best suited to the particular circumstances there is no shortage of problems for the division with responsibility for geriatric medicine

to tackle. These are some examples:

- i. Better information is required about the management of long-stay geriatric patients. Some hospitals produce a list of those in hospital for more than 12 weeks. At this time many elderly patients are not necessarily chronically sick or undischARGEABLE, although if they are in non-geriatric beds they may be regarded as "blocking" beds, and may not be receiving rehabilitative treatment. This problem of "blockage" of beds is a common cause of friction in medical administration in hospital and is often discussed in Cogwheel committees. Information about the diagnosis and prospects of elderly long-stay patients would make it easier to arrive at a practical policy for the individual patient as well as for the hospital as a whole.
- ii. Better information is also required about the management of strokes. This subject was mentioned in the second Cogwheel report as one that would benefit from an exchange of information between doctors and people from other disciplines concerned within the region. Some 67,000 new stroke cases occur every year and a substantial number of patients who survive remain permanently disabled to a major degree. The majority are over 60 and many require hospital care*. Cogwheel divisions will need to consider the particular problem in their own districts, and initiate wider discussions.
- iii. The management of the chronically disabled, as well as those terminally ill with neoplastic and other diseases, is the concern of many geriatric departments. Something like a third of deaths occur at home and most of the remainder in hospital. This is a field in which more research is needed into the type of hospital resources and quality of care required. Although small hospital units and specialist institutions such as Hospices could cater very well for many dying patients, the majority of people who die in hospital will die in an ordinary ward, geriatric or other, and there is a need for better services for the care of (elderly) dying people and improved education for those who provide them. Many of these matters were discussed at a symposium on the care of the dying held in November 1972†.
- iv. Divisions could review the opportunities for joint orthopaedic and geriatric management of patients, and the desirability of establishing a five-day ward for geriatric patients. A recent report on the latter subject‡ shows this may prove to be as useful a development as the day hospital has been.

* Hunt, L. B., *The elderly in hospital: recent trends in use of medical resources*. B.M.J., 22 December 1973.

† Department of Health and Social Security: *Care of the dying: proceedings of a national symposium*. H.M.S.O. 1972.

‡ Parnell, J. W. and Naylor, R. *Home for the week-end—back on Monday*. Queens Institute of District Nursing, 1973.

Psychogeriatric services

38. It has been suggested to us that effective integration of services for the elderly mentally infirm requires that a particular psychiatrist in each district should take responsibility for psychiatric services for the elderly. A paper prepared for us on psycho-geriatric services put the matter this way:

“Where the psychiatric care of the elderly is diffused among the several psychiatrists serving a district, old people are almost inevitably neglected among the competing demands of acute work with younger people. They all too frequently are admitted direct to long-stay wards without proper assessment and these wards rapidly fill up, generating long waiting lists; if they are admitted to short-stay wards they are in danger of being abruptly moved to long-stay wards under the pressure of sudden admissions and there they may be forgotten. There is no one psychiatrist for the geriatrician or the social services to work with, or for the other services to turn to when they need help, whilst on the other hand services may wastefully duplicate each other. The result is frustration, irritability and waning of confidence—only one symptom of which is the tendency of despairing general practitioners to slip confused old people into acute medical beds under the guise of some physical label.”

The main agencies for bringing about integration of psychiatric and geriatric services will be the multi-disciplinary teams that will plan or co-ordinate the delivery of health and social services. Clarification of roles of different clinical specialists and effective organisation of medical services within the hospital, however, are areas in which Cogwheel can and should help.

Psychiatric Services

39. Unlike paediatrics and geriatrics, the clinical specialties of mental illness and mental handicap are most commonly organised in a separate division of psychiatry. The second Cogwheel report drew attention to the fact that psychiatric services in many places had pioneered the development of co-ordinating machinery that cuts across administrative and professional boundaries. In some places the development of multi-disciplinary machinery has taken place separately from, but linked to, the Cogwheel structure; in others Cogwheel divisions and executive committees—especially in single specialty hospital groups—have been used for this purpose in the absence of other initiatives. Little ingenuity will be needed to enable specialties like psychiatry with a large social content and much experience of collaboration with other professions to use structures such as the health care planning team and management teams at various levels for multi-professional co-ordination in the new National Health Service administrative set-up, and to adapt Cogwheel to the new situation.

40. The essential multi-disciplinary nature of present day psychiatry may be illustrated by rehearsing some of the difficulties encountered in organising services for patients. For example:

- i. *Diffusion of care.* A psychiatrist's patient may be seen by different

general practitioners within a group practice; by different members of the psychiatric team when there are changes of staff; by a multiplicity of social workers, particularly with the changes introduced since Seebohm*; or he may be referred by a general practitioner to another psychiatrist.

- ii. *Unclear roles.* Confusion here wastes time and leads to ineffective care. A patient may not be followed up effectively because the general practitioner, psychiatrist or social service department may each expect or assume the other is acting. Even if primary care is firmly recognised as lying with the general practitioner there are times when others concerned think the initiative is theirs. This can lead to double prescribing or contrary advice. Roles depend a lot on what the people concerned can or wish to take on. Their co-ordination cannot be taken for granted or defined in a prior job description.
- iii. *Communications.* Much information lies fallow in people's memories and in odd verbal reports and is not available to be brought to bear on the current situation. Multiple files, even with cross references and reports, instead of one unit file are often one step behind at a given moment.
- iv. *Separate premises and units.* The psychiatrist and general practitioner seldom share premises, such as health centres where they can see patients in consultation. Medical and psychiatric departments for the care of cases of self-poisoning may be in separate hospitals. Two-tier organisation of psychiatric care still exists in some places whereby patients pass from acute units to longer-stay or readmission units, with different sets of staff. This type of organisation is being changed to enable one therapeutic team to see patients all through their psychiatric disability, but it is only too easy for the two-tier system to creep back.

41. Some of these problems arise within the hospital and here the Cogwheel system may be able to help towards a solution. Divisions can review the permanent medical staff required to ensure *continuity of care*, and initiate requests for new appointments. Divisional studies may help to *clarify roles* of hospital staff—the example of psycho-geriatrics has already been mentioned in this connection—but most of the difficulties in this field arise between hospital and non-hospital staff. The development of a single psychiatric hospital record, and central filing may help overcome some *communications* difficulties—this is another subject on which doctors may exchange and crystallise views in the psychiatric division. Nearly all problems that arise require consideration and action on a multi-disciplinary basis, and the function of the psychiatric division (with representation of other senior staff involved) is to provide a forum for their resolution when the matter is one that mainly involves hospital based doctors, or to brief and support clinical representatives in management teams when wider implications call for action at this level.

* Home Department and others, 1968. *Report of the Committee on local authority and allied personal social services* (Chairman F. Seebohm) (Cmnd. 3703) H.M.S.O.

Other Specialties

42. Services for children, the elderly, and the mentally ill or handicapped are not the only ones in which the respective spheres of Cogwheel and multi-disciplinary machinery are not always clear cut. For example, a multi-disciplinary approach has long characterised the organisation of *maternity services*. The relationship between the midwife and the obstetrician or general practitioner is different from that which exists between doctors and nurses in other parts of the service, and working and planning together has for a long while been an accepted part of obstetric practice. This has been demonstrated since 1959 by the maternity liaison committees, composed of representatives of all branches of the nursing and medical professions concerned with the maternity services, which review the overall operation of services. In some places, where Cogwheel divisions of obstetrics have a similar range of membership they have in practice taken over the functions of maternity liaison committees. Where this is so, if the arrangement is acceptable to all concerned we would not want to suggest that it should be abandoned simply for administrative tidiness. In this pioneering field multi-disciplinary arrangements have evolved over a long period of time and are well established. When separate management and planning teams are established, however, we believe it will generally be found best to leave multi-professional action to such teams and for Cogwheel divisions to concentrate on their principal tasks of considering the administration of resources within the hospital, securing co-ordination among hospital based doctors and between them and other functional groups, and examining their own activities.

43. Cogwheel arrangements for the *diagnostic specialties* have special features concerning the inter-relationship between divisions and the management structure, and the involvement in divisions of non-medical staff. In most Cogwheel systems the diagnostic specialties are grouped in two divisions. The division of pathology may include, for example, the disciplines of histopathology, chemical pathology, haematology and microbiology; and the division of radiology includes radiodiagnosis, sometimes in association with one or more of radiotherapy, physics and nuclear medicine. In about one-quarter of Cogwheel systems for which information was available in 1972, the diagnostic specialties were grouped in a single division of scientific services*. The Cogwheel divisions parallel the management structure of departments. Management of individual departments is the responsibility of a nominated head, who may be one of a group of equal consultant colleagues in larger departments, while the function of the division is to review the service its members provide and promote the best use of resources. Some consultants in the diagnostic specialties have had much practical experience—which may be of value to colleagues in other specialties—in combining the role of manager of services with that of collaboration among equal colleagues in a division.

44. Some senior posts in the diagnostic specialties are held by graduate non-medical scientists of equivalent standing to consultant medical scientists. Such

* See Appendix 2, second Cogwheel report.

scientists are usually full members of the appropriate Cogwheel division together with their medically-qualified colleagues, and we believe this should always be the case. Divisions should also invite representatives of other scientific and senior technical staff who work in laboratory departments to attend meetings, as their views—no less than those of spokesmen for administrative and nursing management—should be taken into account before decisions are reached that may have implications for their work.

Membership and role of Cogwheel divisions

45. These considerations apply to all divisions. In general, we believe that membership of divisions should include consultant and other permanent medical staff, non-medical scientists of equivalent standing, and senior registrars, in relevant specialties; representatives of other junior medical staff; representatives from other divisions, as necessary. In addition, the administration, senior nursing staff, general practitioners, and specialists in community medicine, should be invited to nominate spokesmen to attend and participate in divisional meetings. When appropriate, other professional or hospital scientific and technical staff should also be represented at divisional meetings.

46. In managing and planning all health services a pragmatic approach is required. If agreement of and action by hospital based doctors is the main need, the Cogwheel division may well be the best place to resolve problems even though these will nearly always concern other professional staff as well. This is the case, for example, in reviewing the use of hospital beds in particular specialties—decisions are primarily for doctors but they should always be taken in full consultation with nursing representatives. The organisation of intensive care units and re-allocation of operating theatre time are also matters which may best be decided within the Cogwheel system because of the number and variety of doctors involved, but are “multi-disciplinary” in the sense that the other professions have a vital interest in changes that may be made and should be fully involved in decisions that are reached. On the other hand, problems with implications for other professional groups equal to those for hospital doctors will necessarily be handled on a multi-professional basis by standing management or planning teams, or by *ad hoc* planning groups. Examples of the latter might include the introduction of day surgery or the reorganisation of an out-patients department.

47. Cogwheel divisions, even with representation of other professional groups from within and outside the hospital, will not be satisfactory substitutes for multi-disciplinary management teams and health care planning teams when matters of equal concern to a number of different professional groups, medical and non-medical, are involved. There may be some overlap of personnel between divisions and teams but, as we have tried to indicate in this chapter, their functions are different. Furthermore, Cogwheel is a hospital based system and a division is primarily a doctors’ forum. Its membership is, rightly, predominantly medical and in such a gathering other professional colleagues do not

meet with hospital doctors on equal terms. Where inter-professional management and planning is appropriate, doctors—like other professional staff—are best represented by one (or more) colleagues on separate, multi-disciplinary bodies responsible for performing the necessary tasks.

Medical Executive Committee, District Medical Committee and District Management Team

48. An important source of medical advice to the new Regional and Area Health Authorities will be the statutory Regional and Area Medical (advisory) Committees. These committees will represent all branches of the medical profession, will have the right to be consulted, and will advise on the provision of medical services in the area or region. The structure of committees representing medical staff within the *district*—such as the Cogwheel machinery, and the district medical committee representing all branches of the medical profession—is to be regarded as part of the management arrangements as well as part of the professional advisory machinery.

49. The concept of a district medical committee representing hospital based doctors, general practitioners, and other doctors is entirely new. We welcome this development, and hope and believe that the district medical committee will contribute to mutual understanding of problems among doctors working in different parts of the health service, and to a more effective medical contribution in the planning and management of health services. Some doctors, however, have questioned whether the district medical committee has a useful part to play in the new management arrangements. It has been put to us, for example, that the district medical committee is an unnecessary tier which will make demands on scarce clinical time and simply generate more channels through which matters requiring decision will pass. According to this view—with which we do not agree—it is better for hospital based doctors to work through the Cogwheel machinery and general practitioners through the local representative committee (with suitable cross representation between them), each group of doctors nominating a member to the district management team.

50. We can understand the misgivings that lie behind these arguments, but they appear to us to betray a misunderstanding of the respective roles of the district medical committee and medical executive committee. These committees have important and distinct parts to play in the reorganised health service. As in the past, the medical executive committee is needed to co-ordinate medical views on the use of hospital resources and contribute to the formation of plans and operational policies for hospital work ; to co-ordinate the work of divisions, and itself contribute to evaluation of hospital medical activity ; and to provide links between medical staff and administrative and nursing management within one or more hospitals. The district medical committee is too widely based for the

important practical job of co-ordinating medical aspects of hospital work, but only such a committee—composed of representatives of all branches of the medical profession—can bring a truly integrated approach to wider aspects of medical care. The district medical committee is a forum where the medical members of the district management team can meet with a small group of colleagues representing the whole medical profession in the district to discuss and resolve intra-professional difficulties arising from business before the district management team. Not all difficulties can be anticipated or resolved in this way but a committee in which spokesmen for hospital based doctors, general practitioners and other doctors working within the district meet together should bring about a greater appreciation of each other's point of view and a more harmonious partnership among doctors within the district management team. Elimination of the medical executive committee would prejudice the co-ordinating function within the hospital; and elimination of the district medical committee would rob the medical members of the district management team of an important support and weaken their joint influence.

51. We see the district medical committee and the medical executive committee as complementary to each other. It would certainly waste time and duplicate effort if all business between the district management team and the medical executive committee passed through the district medical committee. The medical executive committee co-ordinates hospital medical work as a whole and should deal directly with the district management team on such matters. However, review by doctors of the increasing range of matters which require a common approach by the whole profession in the district, and where difficulties between hospital based and other doctors may need to be resolved, should be dealt with by the district medical committee. This will include major issues of medical policy which are too wide ranging for the Cogwheel machinery and similar committees representing other doctors to handle separately.

52. Membership of the medical executive committee—as with divisions—should include a representative of junior medical staff. Furthermore, the appropriate administrator and nursing officer, the district community physician (or his representative) and a spokesman for general practitioners should have a standing invitation to attend and take part in meetings. As well as helping hospital based doctors to make better decisions, collaboration of this kind will facilitate the work of management or planning teams—and make their job easier for consultant members of these teams—by anticipating and avoiding unnecessary conflict.

53. Different considerations apply to the working of the district medical committee. As part of the professional advisory machinery it is a body through which the medical profession in the district channels its advice on medical policies and priorities to the district management team. Regular attendance at meetings of the district medical committee by senior administrators and nurses would be inappropriate; but we hope that district medical committees will

consider inviting the district administrator and district nursing officer or others to attend particular discussions when opportunities to improve or develop medical services within established policies are being considered. This may help to avoid unnecessary difficulties in the district management team, with consequent saving of time for all concerned.

54. A multi-professional and integrated approach is, rightly, the cornerstone of the management arrangements of the reorganised National Health Service. Such an approach can and should develop in a variety of ways. So far as doctors are concerned it means that it will be unprofitable for them to attempt in their own forums to co-ordinate action by medical staff without taking account of implications for other staff involved. This is best done by inviting spokesmen for such staff to attend medical committees and hearing their views at first hand. It also means that doctors will have to develop arrangements—where they have not already done so—that will enable their own spokesmen to act freely and participate effectively in multi-disciplinary management or planning teams. In a period of administrative change, arrangements which have proved their worth and have taken much time and effort to develop should be preserved and integrated with new machinery designed to meet new administrative needs. Thus, there can be no doubt about the responsibility of the district management team for running the health services in its district. But whether particular matters are effectively settled in management teams, planning teams, medical committees, informal groups, or in other ways should depend on how the best decisions can be reached with the most economical use of time by those involved.

Demands on clinical time

55. There is a great deal of anxiety among clinicians that they will not, in practice, have the time to play a full and proper part in the management arrangements for the reorganised health service. The medical profession has itself sought greater involvement by clinicians in planning and management. Consequently, when reorganisation is fully implemented, doctors will have more opportunities to contribute on decision making bodies. Some of the tasks falling to clinicians—for example, membership of the district management team—are time-consuming and have no exact counterpart in past management arrangements for hospital services. The district management team has wide responsibilities and time has to be found to attend meetings and to be adequately briefed on the matters coming before the team. Experience with the Cogwheel system has shown that much time may also need to be devoted by spokesmen to explaining and winning support for decisions among clinical colleagues. The role of representative clinicians turns on being able to give effect to decision and achieve results.

56. The ability of clinicians to meet these demands depends partly on arrangements they themselves make or are prepared to agree to ; and partly on support they are offered and are prepared to accept. It also depends on the possibilities of securing some relief from clinical work for doctors with administrative duties. Involvement of consultants as chairman or vice-chairman of the district medical committee, and as members of the district management team and health care planning teams, represents an additional commitment. We believe that health authorities should take administrative duties of doctors into account when planning their medical manpower requirements. Consultants who give up some clinical work to devote more time to administration should be given an undertaking that their full clinical facilities will be restored when they relinquish the extra administrative work. Consultants who do not formally surrender clinical responsibilities will need and should be given whatever clinical support is possible ; for example, by redeployment of junior medical staff or increase of clinical assistant help. Flexibility and experimentation are needed in making arrangements that will enable clinicians to take on extra administrative work. To be effective, such arrangements will require the full support of clinical colleagues and sympathetic co-operation from the health authority.

57. Two other ways in which doctors themselves can conserve time while participating in management arrangements on a broad front are to share jobs widely among themselves, and to be prepared to work through representatives. The following are examples of how administrative work may be shared.

- i. The consultant member of a health care planning team will seldom be the chairman of a division. The positions are best held by different doctors, although they will need to work closely together.
- ii. A member of the division other than its chairman can represent it on the medical executive committee. A medical executive committee composed mainly of divisional chairmen is regarded as the best arrangement in some places at present but this is not essential. Some Cogwheel systems are based on the opposite principle—that no divisional chairman should be on the medical executive committee—and have proved to be very effective. An example of this kind at the United Birmingham Hospitals was mentioned in the second Cogwheel report. In this particular instance the medical executive committee is also directly elected by all the consultant staff and it is possible, therefore, to have a committee with a membership smaller than the number of separate divisions. This represents a further saving of clinical manpower but—as the second Cogwheel report acknowledged—this particular feature may not be acceptable everywhere, or work as well in some other places as it undoubtedly does at Birmingham. A medical executive committee which is composed entirely or predominantly of representatives who are *not* divisional chairmen, however, does make it easier for individual members of the committee to take on other responsibilities which membership should entail.

- iii. Though there might be some overlap in membership between the medical executive committee and district medical committee to ensure harmony of working this could be minimal. It would be unwise for the consultant member of the district management team (who will usually also hold office in the district medical committee) to be chairman of the medical executive committee as well, as these are among the most time-consuming administrative jobs done by hospital doctors.
- iv. Some of the tasks of chairmen may be relieved by sharing responsibility for particular subjects among members of the committee—whether the medical executive committee or the district medical committee. A “cabinet” system of this kind already exists in some medical executive committees and could be more widely applied. A doctor who specialises in a particular subject and co-ordinates activity could take the lead on the subject within the medical executive committee or district medical committee, and brief the clinical members of the district management team when it comes up at that level. At medical executive committee level it will usually be easier to make arrangements of this kind when the committee is not exclusively composed of divisional chairmen.

58. The new management arrangements will not work so far as doctors are concerned unless there is considerable development and acceptance of representative arrangements. In the past, freedom to act on behalf of hospital based doctors has been needed only in a limited number of cases, and then within the confines of the hospital group. In future, doctors who serve on planning teams, management teams and the district medical committee will need this freedom, as well as divisional chairmen and the medical executive committee. Matters affecting hospital doctors must, of course, be fully discussed and a consensus view reached in Cogwheel divisions and medical executive committees, but if doctors are required (or feel it necessary) to refer back frequently to colleagues their work will be increased and their influence in multi-professional teams weakened.

59. Methods of selection will certainly affect the ability of spokesmen to command confidence among colleagues and win their acceptance of decisions reached in multi-professional teams. The second Cogwheel report noted that in all known cases chairmen of divisions and medical executive committees had been elected by their colleagues and mentioned instances where elected representatives enjoyed considerable freedom of action because of the confidence reposed in them. There are many ways in which representation can be secured but the Cogwheel system will usually only work well if doctors themselves decide on their own methods of choosing colleagues to speak for them. The particular arrangements are not important so long as they command the confidence of medical staff concerned. This applies to the selection of clinical members of all multi-professional teams. If doctors are able to choose colleagues as their

spokesmen in ways that seem to them most appropriate in local circumstances they are more likely to allow those spokesmen the freedom of action necessary to make multi-professional planning and management work successfully.

60. Wider sharing of responsibilities among doctors and greater use of representatives will help to make the individual load of administrative work for clinicians tolerable. But clinicians also need suitable supporting services in their administrative work, both as members of divisions or committees reviewing the services they provide and as representative doctors in multi-professional teams. With regard to the former, the Working Party's second report saw the need for supporting services as falling in three categories. Basic administrative services for Cogwheel divisions, committees and chairmen are required to enable the system to function at all. Higher level administrative support is also needed to help clinicians to identify and tackle problems or formulate and pursue objectives. At this level, as the second report observed, "the important thing is to ensure the close meshing of the Cogwheel structure with the hospital administration for when problems are tackled jointly by doctors, nurses and administrators working as a team the resources of the administration are harnessed to their solution".* Suitable information services are also indispensable and we refer to this subject in later chapters. These supports must be forthcoming so that the time devoted by clinicians to administrative matters may be put to the best use, whether by being relieved of tasks that others can and should perform or by being helped to discharge effectively responsibilities that necessarily fall to clinicians.

61. The other task in which clinicians need support is their role on management teams. Here full-time clinicians are also part-time administrators and may experience some difficulty in finding time to do the job as they would wish. However, not all the matters coming before management teams require the same degree of involvement on the part of clinical members, who should not need to undertake duties that full-time officers can perform equally acceptably and well. Administrative work falling on the clinical members of the district management team will be eased if they have a close working relationship with the district administrator and the district community physician. As the amount of time in which the district management team can meet and function is limited by the availability of the representative members, their colleagues who are full-time administrators will have to do a great deal of work to promote the effectiveness of meetings.

62. We see the district community physician, in particular, playing an important role in support of and in collaboration with his clinical colleagues on the district management team, the district medical committee, and indeed within the Cogwheel arrangements. He will co-ordinate and facilitate the working of health care planning teams, where again he will be able to support clinical colleagues. It may take time to establish the necessary rapport. Some consultants regard

* Second Cogwheel report, paragraph 6.5.

the role of district community physician with suspicion, and fear that his part in helping to determine priorities will bring him into conflict with consensus views reached among clinicians. We think these fears are groundless. The aim of the district community physician like that of his clinical and other colleagues in management or planning teams is to help secure the best use of resources, and highest possible standards of service, in meeting the health needs of the district. In pursuing this aim, the special skills which the district community physician should be able to bring to the planning and organisation of health care can help clinical colleagues to make a more effective contribution of their own when reaching consensus in medical committees, when putting the medical viewpoint in multi-professional teams, and when securing the implementation of agreed decisions. This should result in greater combined medical influence in determining and giving effect to priorities.

3 EFFECTIVE CARE

Introduction

63. The terms of reference of the Working Party required it to look for ways of improving efficiency in the organisation of medical work in hospitals. Earlier reports concentrated on the organisation needed at local level to enable doctors using more or less defined resources to come together, with other professional staff, to review their work. The central concern of the Working Party has been that a more informed use of resources—whether people, facilities or money—should enhance the quality of care provided by making it more effective, or more efficient, or both.

64. The efficient use of resources has sometimes been regarded as synonymous with effective use. Professor A.L. Cochrane has explored these terms in the context of a cost-benefit approach to medical care*. He used the term “effective” to describe particular medical actions which research had demonstrated to have measurable effects in altering the natural history of diseases for the better. Under the efficiency heading came all the problems of the best use of people and materials in achieving results through various methods of screening, places of treatment and lengths of stay. The Working Party in its discussions has also tried to separate the effectiveness and efficiency issues affecting medical work carried out in hospitals. Efficiency issues may be problems of bed use, or of planning services. Many may be related to medical work while not being the immediate concern of medical staff and their study may properly be initiated and handled by the non-medical administrator with professional advice. Divisions, medical executive committees, other skill groups, and hospital management generally have all been concerned with short and long term planning of resource use, development of services and improvements in services. Some efficiency issues are very much the concern of medical staff. Thus, considerable attention needs to be devoted to the educational and

* Cochrane, A. L., *Effectiveness and efficiency*. Nuffield Provincial Hospitals Trust, 1971.

training content of posts for junior medical staff. This subject is now receiving more scrutiny from the Royal Colleges and from junior staff themselves than has been common in the past, and this trend is likely to become more marked. Much time has also to be spent dealing with off-duty rotas, extra duty payments, allotment of theatre sessions, registrar rotation schemes, and vocational training for those wishing to enter general practice. Clinicians usually accept these duties as well as involvement in other less medical and more administrative activities.*

65. This chapter, however, will deal with the group of matters which come under the general heading of the *effectiveness* of medical care. These may be questions about the clinical efficacy of a particular procedure or regime, the quality and effectiveness of one pattern of treatment against another, or the way in which medical priorities are determined. They are not completely separate from efficiency issues and in many instances overlap. Introducing a paper about major out-patient surgery, a Lancet leader† said that medical organisation is “staggeringly inefficient” in some areas of the National Health Service. It advocated a system with a number of ingredients which would improve the organisation of elective surgery, and concluded that “it may be thought that a system like this is more concerned with efficiency than with quality of care. But the one is likely to lead to the other. Furthermore, there is nothing that gives a patient more confidence than evidence that a little extra thought and individual foresight has been devoted to his surgical care”. The recent description of the programmed investigation unit of the Manchester Royal Infirmary‡ is a vivid account of efficient procedures, not solely investigative, for medical patients. It is described as an adventure in organisation, but the stress laid upon the patient’s preference for a particular date for admission, improvement and updating of instructions for tests, and explanations to patients about tests, emphasise the quality of service provided.

What divisions can do

66. The second Cogwheel report made some reference to the substance of medical work, as distinct from the system for providing hospital care. It suggested that:

- i. The divisional system encourages exchange of clinical experience and might be expected to assist the dissemination of good medical practice.
- ii. A conscious effort to evaluate a new clinical development and to include it in postgraduate education programmes should be made and would be easier if there was collaboration within a region.

*See, for example, Hart, H. T. *Clinical divisions and clinical management*. Health and Social Services Journal, 8 December 1973.

†Lancet, 24 November 1973.

‡Longson, D. and Young, B. *British Medical Journal*, 1973. 4: 528–531.

- iii. The introduction of some developments might best be effected by using regional teams to visit and advise locally. In some situations a region might have no medical staff experienced in a particular technique and might need to arrange for individuals to visit or train outside the region so that this could be acquired. This might apply not just to a development such as renal transplantation but also to those less homogeneous situations which require the integration of people in a number of professions in the hospital and community services, as in the care of the mentally ill.

The report did not spell out these suggestions in detail apart from giving a few examples of clinical conditions (acute myocardial infarction was one) where there is already enough information to allow pertinent examination of existing practice.

67. It is even more necessary to continue study of the effectiveness of treatment of the common every day conditions than to evaluate new, less common, activity. The management of patients with stroke, care of the elderly mentally infirm in hospital, care of the dying, treatment of pressure sores, are problems in almost every hospital. Perhaps because they are common to all they excite less interest, fewer policy reviews, and little research compared with “acute” problems.

68. British doctors are not expressly required to carry out detailed appraisal of the quality of their work, the outcome of surgical intervention, or the need for particular investigations in various clinical situations; or to compare the outcome of treatment in different places. Nevertheless, an increasing literature shows that there is growing recognition in medicine of the need for regular reviews which allow comparisons to be made. Reviews may be conducted at local, regional, national and—in some medical care fields—even international levels. Examples of such reviews given later in this chapter could fairly easily be applied to other clinical situations. Consideration of published studies of clinical practice should be a regular part of divisional activity. These could be used, in appropriate cases, as a basis for comparing local performance with results achieved elsewhere and for arriving at possible local applications.

69. Some studies could be initiated at divisional level or over a wider area. An important example of a comprehensive review of practice is that of perinatal mortality made at regular meetings in many maternity departments in Britain. In some this review is extended to neonatal morbidity and also obstetric practice. The inclusion of obstetricians and paediatricians, specialist and trainee alike, together with general practitioners and midwives, provides an interdisciplinary group which ensures that agreed changes in practice will be implemented. The value of this open and critical approach to perinatal hazard cannot be too strongly emphasised. Reviews of anaesthetic deaths or mishaps, adverse drug reactions, and other clinical events where pooling of information seems very desirable could also be carried out at the initiative of divisions on a

regional or an area basis. The number of hospital admissions for adverse reactions to drugs is now so large (over 80,000 each year) that there is an obvious need for local reviews of the use of at least some of the more potent drugs.

70. As well as the retrospective type of survey, which often aims to discover what went wrong in order to avoid making the same mistakes in the future, medical executive committees and divisions may have opportunities to plan clinical work in a prospective and systematic way so that a broad and general clinical policy can be established for the hospitals of a district and continually reviewed to achieve improvement. When a number of consultants are using a facility such as an intensive therapy unit or a coronary care unit, junior staff—particularly newcomers—need to know what is the clinical policy for patients within the unit. Junior staff may be expected both to contribute to this type of review and to benefit from it. Since doctors in training may gain experience in more than one similar hospital or department and indeed often bring refreshment and innovation by so doing, it is important that clinical policies can be seen against the background of alternatives which they may encounter in their career. This is equally or even more necessary in the care of those who are chronically ill. Doctors in general practice are likely to spend much time looking after the dying, the elderly mentally infirm, or patients who have had a stroke or a psychiatric illness, and their hospital training should reflect this.

71. The community facets of substantial parts of hospital work and the role of multi-professional teams and the district medical committee in securing a fully integrated health service have been emphasised in Chapter 2. Many Cogwheel divisions will be concerned with the effectiveness of linked hospital and domiciliary services. Buckley et al* have stated that outpatient surgical work requires at least 12 written communications and 6 telephone calls for a patient whose operation runs into no snags. Short-stay surgery and obstetrics need proper backing from services provided at home.† In some maternity units the length of stay of uncomplicated cases is determined entirely by the domiciliary team rather than by hospital staff, on the basis of assessments of social and domestic circumstances. Such practices have united hospital and domiciliary services in the best use of the resources of each.

Review of clinical practice

72. The following are just some examples from published and unpublished studies, some based on controlled clinical trials, which may be adopted or subjected to further assessment but which concentrate on the development of good medical practice and the evaluation of care provided.

* *Major outpatient surgery.* Buckley, C. V., Maclean, M., Ludgate, C. H., Espley, A. J. *Lancet*, 24 November 1973.

† Memorandum on the arrangements for the care of persons attending hospital for surgical procedures as day patients (Department of Health and Social Security, July 1973).

International studies

73. National and international data on the use of services and on morbidity and mortality statistics have been accumulating. The following are just a few of the publications in the international field: "An international study of health expenditure", Abel Smith (World Health Organisation, 1967); "What is value for money in medical care?", Logan, Berfenstam et al Lancet 1967; "Hospital Caseloads in New England and Uppsala", Logan, Berfenstam et al Lancet 1968; "Custom and Practice—Medical Care" (comparison of Arbroath and Waterville, Maine) Simpson et al, 1968; "Comparison of Surgical Operations", Bunker et al, New England Journal of Medicine 1970. International comparisons of the sort described in these papers have to be interpreted with care because the data used are not very refined and not always strictly comparable. This point has been emphasised by Sir Richard Doll* who has commented on the frustrations of trying to compare mortality rates for different countries over a period of time. Such comparisons may show a real difference in the incidence of disease and mortality rates, a difference in medical practice, or differences in social circumstances or past custom. International comparisons are a happy hunting ground for health authorities and individual practitioners who are concerned with "... inherited patterns of health services and expectations, and ... value for money and resources deployed"† and may raise interesting questions which are worth further pursuit.

National studies

74. National sources of information on disease patterns in this country come from four main sources. These are figures of mortality, notifiable communicable diseases, hospital deaths and discharges, and claims for sickness benefit. Again, deduction from any of these has to be cautious; even mortality data have to be interpreted with knowledge of errors in certification, changes in diagnostic habits, and periodic revisions of the international classification of disease. The annual reports from the Department of Health and Social Security provide a consistent commentary on deaths associated with infancy, childhood, pregnancy, infectious diseases and many other causes. This routine information is supplemented by special studies such as those conducted by the Office of Population Censuses and Surveys into the incidence of disability and the survey of adult dental health. Both types of data may be used as yardsticks for comparing local activities and achievements against national or regional norms.

75. Mortality figures may be used in the study of causation of diseases; for instance, the differing death rates from cancer between social classes and occupational groups, while the geographical factors in death rates from coronary heart disease have led to searches for environmental factors in causation. Other national studies have been carried out using data on deaths. The confidential enquiry into maternal mortality is conducted regularly on data

* *Monitoring the National Health Service*. Proceedings of the Royal Society of Medicine, Vol. 66, August 1973.

† *Hospital caseloads in Liverpool, New England and Uppsala*. Pearson et al., Lancet, 7 September 1968, p. 559.

spanning 3 years. Pledger and Buchan (BMJ 1969) reported on deaths from acute appendicitis in children under 15 during the 5 year period 1963–67 and recommended a wider use of “national medical audits”. Riley* reported on post-neonatal mortality in 3 areas, Butler and Bonham’s perinatal mortality survey† provides a detailed and national review in less depth, and recent work by Cross (Lancet, 27 October 1973) has shed more light in this field and on the needs of new born and premature infants. But most of these studies are of mortality and most patients do not die. Methods need to be developed for more thorough review of what happens to survivors.

Local and regional examples

76. International and inter-regional comparisons, however fascinating the discrepancies or anomalies they reveal, have only limited use unless they are of value to people who are in a position to apply the findings to their own local situation. The practice of undertaking studies directed towards particular patient groups, both locally and regionally, is increasing to meet the problems of introducing new techniques of practice into existing restricted circumstances. The following are some examples.

- i. The establishment of special units for the treatment of leukaemia and for chronic renal failure has been associated with the collection of data on morbidity and mortality, and with continued evaluation and comparison of the quality of medical care being provided in these units.
- ii. The abundant literature on myocardial infarction demonstrates the efforts of epidemiologists and clinicians to evaluate prevention and treatment. The literature covers not only the use of analgesics, anti-dysrhythmic agents and anticoagulants, but also sources of delay in obtaining treatment, the outcome of care provided in the different circumstances of home or a designated special unit, the outcome of early discharge and ambulation, and a wealth of detail on risk factors.
- iii. At least one region has made a detailed study of its therapeutic abortion practice. Whilst it is often maintained that this new activity displaces others to the overall disadvantage of patient care, information provided by all the consultants in one region and co-ordinated by a working party indicated where the greatest pressures existed, measured the work load against competing claims on resources, and identified problems of referral and admission of patients. Each part of the region was invited to review its experience and practice in the light of experience and practice in other parts of the region, and to claim for extra resources where the work load, and the total interests of all patients in the specialty group, justified this.
- iv. National and regional data were used in a study of perinatal mortality in the Reading area. This study led to a reassessment and revision of the local policy for admitting patients for delivery to general practitioner maternity units.

* Department of Health and Social Security, *Confidential enquiry into neonatal deaths, 1964 to 1966*. H.M.S.O. 1970.

† Butler, N. R. and Bonham, D. G., *Perinatal mortality: first report of the 1958 British perinatal mortality survey*. Livingstone, 1963.

77. Published national statistics are broken down to give information for hospital regions or local authorities. Some of the most informative but least used national and regional figures are contained in the published summaries of the Hospital In-patient Enquiry. Regional variations in length of stay of patients with hernias, and case fatality rates for hyperplasia of the prostate attracted the attention of epidemiologists and led to some special studies. Two of these were reported on in the following articles: "Early discharge after hernia repair", Morris et al, Lancet 1968; and "Case fatality of hyperplasia of the prostate in two teaching and three regional board hospitals" Ashley et al, Lancet 1971. The Oxford record linkage system, identifying individual patients through sequences of shared care, provides clinicians in the area with various types of data—either as a routine or in response to requests received from divisions and medical executive committees, or from individuals.'

78. Other regions may not be equipped with the particular facilities available in the Oxford region but most have information units, management services departments or access to University departments of community or social medicine. Academic units, many of which are supported from research funds by the Department of Health and Social Security*, usually have long term research goals partly determined by the staff appointed to them. However, the appointment of a Chief Scientist at the Department, together with supporting advisory machinery, is expected to achieve priority for research to improve the effectiveness and efficiency of the National Health Service, so far as government-funded work is concerned.

79. Hospital activity analysis (HAA) is available to most Cogwheel systems as a limited but valuable aid when divisions or individual clinicians review episodes of in-patient medical care. Consultants are supplied with data which records the diagnosis, age, and sex, of their patients, the length of time they were treated in hospital and whether or not they died, facts of which they must be aware but do not necessarily review in series. In Scotland, comparable national information is provided as a framework in which to set that given to the individual†. If all the consultants are agreed, pooled data can be provided for a unit or firm of consultants. HAA and its equivalent in Scotland are essentially private. It cannot be used by a regional board or any other authority, or even by a group of physicians at the source hospital, to insist on changes. The existence of a 'norm', whether it be length of stay in hospital or the mortality rate for an operation, does not in itself justify asking a clinician to conform to that norm, though it does give him a yardstick against which he will, no doubt, compare his own results.

* *Portfolio for Health I and II*, published in 1971 and 1973 by Oxford University Press for the Nuffield Provincial Hospitals Trust, describe the programme of research supported by the Department of Health and Social Security.

† *Scottish consultant review of inpatient statistics*. Heasman, M. A., Scottish Medical Journal, 1970. 15: 386.

80. A quality control scheme for biochemistry laboratories has been conducted on a voluntary basis for some years. Its objectives are:

- i. to provide free distribution of quality control service to all hospital biochemistry laboratories in the United Kingdom;
- ii. to enable laboratories to compare their results with those obtained in other laboratories over the rest of the United Kingdom;
- iii. to study the effect that differing methods may have on the result produced.

While it is obviously important that diagnostic departments should analyse their own practices it is equally important that those who seek the services of such departments should consider from time to time whether tests requested are necessary. A survey of investigations carried out might well cause clinicians seriously to consider whether they are in the best interests of patient care and resource use, or whether they have simply multiplied with the years and the development of new tests. Ashley et al*, looking at hospital variations in numbers of tests ordered for selected diagnoses in 1972, suggested how Cog-wheel groups might approach the problem. Other authors have looked at the value of a particular test or investigation and its influence on subsequent diagnosis or patient management†.

81. A number of the studies at local and regional levels described in the preceding paragraphs have a strong research flavour to them. Not all measures taken to help services to improve have this academic base. Some regions have found it beneficial to establish visiting teams to look at care provided for particular groups of patients. This type of activity developed in the wake of the Hospital Advisory Service which has the task of visiting hospitals for the elderly, and the mentally ill and handicapped. There are strong arguments for devolving the responsibility for such reviews on to those involved in providing the service within the region. Those who visit and advise—as well as those who seek advice—may be expected to profit through meeting others in their own specialty and seeing the work done by them. Visiting team members would identify needs and channel specialist advice at Regional or Area Health Authority level. The use of visiting teams could spread to some of the acute specialties, where services may need to be planned and developed in the light of local circumstances and with the assistance of people with particular specialist knowledge. Activities of this type could be associated with formal postgraduate training arrangements, which would develop and disseminate new treatment methods where appropriate. This has happened to some extent in the treatment of leukaemia in childhood and might be expected to spread to other fields such as rehabilitation.

* *How much clinical investigation?* Lancet, 22 April 1972.

† *Rationalising requests for X-ray films in Neurology.* Bull, J. W. D. and Zilkha, K. J. *British Medical Journal*, 1968, 4: 569–570.

Is the xylose test still a worthwhile investigation? Sladen, G. E. and Kumar, P. J. *British Medical Journal*, 1973, 3: 223–225.

Conclusion

82. The practice of medicine in Britain is becoming increasingly related to a population as a whole. The use of epidemiological tools and reviews such as those described above are examples of this broader approach. They set the individual patient in a wider context, the consequences of his clinical care being related not only to himself but also to his family and society. We believe that such organised and systematic assessment can only benefit the practice of medicine.

83. The clinical freedom of the individual doctor in his investigation or treatment of his patient is a principle upon which the profession has rightly set great store. This principle must be maintained in the interests of patients as well as of the quality of medical work and it should be interpreted in the context of today—not of the medicine of 50 years ago. If clinical freedom is the freedom to fulfil the individual contract between doctor and patient within the limits of the resources available it must vary from one branch of medicine to another and according to the situation of both doctor and patient. It depends for instance on the extent to which a clinician is practising with simple personal resources, or as a member of a team with complex and shared resources. The clinical freedom of a dermatologist has less dependence on resources than that of a radiotherapist. The freedom of a surgeon to practise depends upon his supporting team and his share of theatre use and upon his anaesthetic colleagues. The surgeon could not operate on a patient considered unfit by the anaesthetist. The clinical freedom of a junior hospital doctor is strictly limited both by his experience and the discretion given to him by his seniors.

84. The Working Party does not believe that standard patterns of treatment or investigation should be imposed, however expert the group which define them. It does believe, however, that in many circumstances the individual clinician needs to have regard to the collective view of his colleagues on best current practice in particular situations. He is not bound by those views but he should be able to defend to himself, and if necessary in collective discussions with his colleagues, the choice of a different approach. This is not to say that he is answerable to them for making such a choice but that the choice should be made with full awareness both of the general principles and of the factors involved in the particular case.

85. The machinery for doing this will vary from place to place but divisions have a clear role. So too have medical executive committees in securing co-operation between divisions and perhaps by initiating some assessments of medical work through direct inquiry. The district community physician should be a valuable source of help and information backed up by University departments of community medicine, or by research and intelligence units of Regional Health Authorities. But the principal contribution comes from those who are responsible for patient care. Those who contribute will have agreed on several important issues—such as the degree of confidentiality of pooled data, the

availability of results, the critical functions given to any experts asked to assess. In return they will expect to know more about the background against which they practise and the interdependence of their specialty with others. They will hope to see a measurable improvement in care through changes in practices by individuals, or through the increase or redistribution of resources.

4 SOME FURTHER ASPECTS OF COGWHEEL

86. The Working Party has given particular attention to the subjects dealt with in the preceding chapters because of their importance at the present time. But we considered other aspects of Cogwheel at our meetings—and in this chapter we report on some of our discussions and conclusions.

“Supra-District” specialties

87. The organisation of medical work in specialties which serve a larger population than the district in which they are based present special problems. These specialist services may operate from a variety of types of hospital, or sometimes from units attached to specialist hospitals with or without some other function. They are of two main kinds:

- i. “discrete”—for example, radiotherapy, plastic surgery, neurosurgery where the specialists are readily identifiable as such. If they have links with other specialties they are usually clear, such as neurosurgery with neurology.
- ii. “ill-defined”, in the sense that some elements of the specialty are normal district provision whereas others may be “supra-district”. Paediatrics is an example of this kind. A further complication is that some specialties in this group (for example, cardiology and urology) are practised by generalists with an interest in the specialty as well as by clinicians whose work is wholly devoted to the specialty.

88. In the “discrete” group of specialties a specialist unit may serve a population of an area or even a region, but nevertheless operates within an organisation otherwise primarily concerned with a district population. The specialty (that is, its consultants and related staff) needs to establish links, therefore, at two levels. It must link with the other specialties in the hospital or group of hospitals in which its main function is discharged. At this level its problems are those which are common to all specialties and can be tackled within the district Cogwheel arrangements. Such a specialty may be numerically quite strong and of high status. Nevertheless, its impact on its immediate surroundings (for example, use of theatres, need for anaesthetists, use of service specialties) is similar to that of any other specialty. It can, therefore, reasonably be included in a general surgical, medical or service division as the case may be although, if very large, it may justify a division of its own. Thus, on local administrative matters its voice is heard through the normal channels of district management.

89. However, such a specialty also needs to function at a level related to the population it serves. This could be achieved by an organisation similar to a

Cogwheel specialty division but free-standing; that is, not contributing to any medical executive committee. This wider grouping would carry out the functions normally falling to a division of appraising the service it provides, deploying clinical resources as effectively as possible, and contributing to policy making and planning. It would advise the appropriate health authority through the area (or regional) medical advisory committee, and would function in the same way as other specialty sub-committees.

90. In the "ill-defined" group of specialties the situation is more complex and indeed fluid. At district level, the specialty will usually be part of a general division (for example, cardiology or neurology in the division of medicine) although it may be in a division of its own (such as paediatrics in some cases). There may be a case, however, for a specialised sub-committee at area or regional level, to function as a division would but in relation to matters that require review at a level above that of the district. The sub-committee would have to relate to the management structure through the medical advisory committee at the appropriate level. It would be wrong to try to lay down hard and fast patterns but medical advisory committees should review the need for such arrangements in their areas or regions and make whatever provision appears to be needed in local circumstances.

91. A suggestion made to the Working Party about the organisation of service responsibilities of academic departments of paediatrics illustrates what supra-district arrangements might be able to achieve in this sphere.

"If there were some sort of organisation to which academic departments, as well as other large medical centres, had some sort of responsibility, we could envisage joint planning in terms of staff and the production of training rotation which would offer young people an opportunity to select and apply for a training rotation which would most nearly suit the type of paediatric career at which they were aiming. In addition, if some academic appointments could be made . . . (at regional centres) . . . it would enable research interests to be spread through the region, as well as perhaps enabling the high technology services of the region to be better planned. . . . There should be some body which should decide at which centre high technology system specialisation should take place with an understanding that within the region there should, as far as possible, be referral of (suitable) cases to the designated centre."

Arrangements such as these would avoid the danger of a number of centres developing their interests unilaterally without due regard to the overall needs of the population within a region or part of a region. They would also avoid over-centralisation of high technology services and the corresponding danger of lower job satisfaction at centres not providing such services. Although the particular suggestion concerns the relationship between academic departments of paediatrics and other large medical centres, the underlying approach could have wider application.

92. In putting forward these suggestions the Working Party is not proposing the establishment of a “regional Cogwheel system”, or interference by the region in the responsibility of areas and districts to implement agreed plans. However, where a specialist unit serves a population larger than that normally served by a district general hospital there is a need for machinery above district level to enable clinicians (in association with others) to review the service they provide and contribute effectively to planning. In such specialties, the divisional structure at district level cannot serve this purpose adequately; although no consultant—however “rarified” his specialty or interests—should be debarred from taking part in the Cogwheel organisation where his activities are based. The level at which special machinery is needed (area or regional) and the particular form it should take are matters for local determination.

Undergraduate teaching hospitals

93. Most undergraduate teaching hospitals have adopted at least a partial Cogwheel system and the second Cogwheel report drew on the experiences of several of them. Nevertheless there are a number of reasons why it is more difficult for teaching hospitals* to achieve the aims set out in the Working Party’s first two reports than, for example, a medium sized group of hospitals without substantial teaching responsibilities. It is important to attempt some assessment of the difficulties because it is becoming common to administer hospitals in large groups, and more hospitals are taking on some undergraduate teaching responsibilities.

94. The problems may be categorised as follows:

- i. Teaching hospital groups have larger numbers of medical staff, more specialties, and a higher proportion of medical staff in the training grades than most other hospital groups.
- ii. They attract departments with specialised interests which require representation at discussions. Many of these departments provide a supra-district service and may present the difficulties discussed in earlier paragraphs of this chapter.
- iii. The teaching commitment brings an extra dimension into all considerations of resource use and service. This adds a further factor to the natural caution which medical staff have about redeploying resources; for example switching under-used beds from established specialties.
- iv. Appointments to university posts are made primarily with the academic abilities of the individual—rather than service needs—in mind. When he leaves, the hospital is often left with a developed clinical service to continue while his successor may need different facilities. This can have a considerable effect on the use of other resources (such as nursing services).
- v. The university hierarchical system can cut across the Cogwheel concept especially in diagnostic specialties where there is a tendency to make the

* Paragraphs 93 to 97 refer to *undergraduate teaching hospitals* but, for convenience, these are referred to simply as “teaching hospitals”.

professor head of the service as well as the teaching and research aspects.

- vi. There is a greater personal stake in building up a university department where staff and equipment are directed towards individual research interests.
- vii. The university commitments of teaching hospital staff tend to reduce the time and commitment which some can give to the hospital medical organisation.

95. These problems add up to a need to encompass a wide range of special interests, a large number of medical staff, and links with many support staff, within the Cogwheel system. The practical difficulties to which they lead are the size of divisions and medical executive committees, the overstretching of the structure to encompass every activity under the medical executive committee umbrella (library, research, medical school), multiplication of divisions and sub-committees, and much paper work and difficult communications. At the organisational level the problem crystallises into democracy versus effectiveness. Can medical executive committees and divisions be kept small enough to work effectively while catering for the representation of a wide range of interest and the maintenance of good communications?

96. This particular problem has been tackled in three ways:

i. *Large medical executive committee and large number of (relatively small) divisions*

Most teaching hospital groups appear to have accepted the need for a large number of divisions and a correspondingly large medical executive committee. Communication between divisions and medical executive committee is usually good, and the arrangement encourages a high degree of participation. However, the relatively large medical executive committee (over 20 members in some cases) may not be significantly more effective than former medical advisory committees in reaching difficult decisions or stimulating action. In practice, a caucus of officers and leading members sometimes develops within the medical executive committee.

ii. *Small medical executive committee and small number of (relatively large) divisions*

In some places a large medical executive committee is avoided by resisting the tendency to create separate divisions for the range of specialties practised in the hospital. Divisions are larger, include more specialties, are less able to cater adequately for discussion of problems of particular specialties, and may accordingly find it difficult to secure a high degree of participation. An unusual example of this kind, which works well in the particular circumstances, is at the United

Oxford Hospitals where there are only three large general divisions*. Such a small number of divisions would not be acceptable in most teaching hospitals but the method as used elsewhere produces a medical executive committee of up to about ten members.

iii. *Small medical executive committee and large number of (relatively small) divisions*

This method seeks to combine the advantages of the two former methods, by a directly elected medical executive committee rather than one composed of representatives of all divisions. In this way, it is possible to have the number of divisions that appears appropriate without this affecting the size of the medical executive committee. This method of selecting the medical executive committee, and the large number of divisions, encourage a high degree of participation but—in the absence of formal links—possibly at some sacrifice of the ease with which the medical executive committee can communicate with divisions and co-ordinate their activity. An example of this kind at the United Birmingham Hospitals has been mentioned earlier in this report (paragraph 57).

97. There is no “best” method of setting up Cogwheel arrangements in teaching hospitals. Each of the methods mentioned above function effectively in particular places. The right approach is by experiment to find the system that works best in local circumstances. If a large medical executive committee based on a large number of divisions proves ineffective, it may be possible to reach agreement on reducing the number of divisions and thereby the size of the medical executive committee. Alternatively, a small medical executive committee whose size is independent of the number of divisions—either being directly elected, or representative of the larger divisions and groups of smaller divisions—may be more acceptable. Whatever arrangements are adopted, they should be accompanied by good communication of decisions and policy, and lead to the development of a medical executive committee which:

- i. is characterised by consistent attendance of members.
- ii. has independence of view, while ensuring adequate representation of university as well as National Health Service medical staff.
- iii. is effective as a decision making body and as a stimulus to divisional activity.
- iv. is well enough informed about National Health Service management to be an authoritative voice in discussing policy decisions with new health authorities. This is particularly important for teaching hospitals at the present time as many have not had close contacts with other health services provided in their area, nor have they borne full responsibility for some of the most difficult hospital services, such as those for the elderly and the mentally sick.

* Their chairmen are joined by a fourth doctor, elected by all medical staff, to form the “Medex” (medical executive committee) and, prior to reorganisation, the medical component of the executive committee of the Board of Governors. See Sleight, P., *et al.*: *Oxford and McKinsey: Cogwheel and beyond*, *British Medical Journal*, 14 March 1970.

Postgraduate medical education

98. The first Cogwheel report said that “because of the pattern of medical staffing and the apprenticeship character of much vocational medical training, no hospital nowadays can afford not to be a teaching hospital in some sense.” The expansion of postgraduate medical education since then adds weight to this view. In every region there is a postgraduate education committee with a postgraduate Dean as chairman or chief executive officer. Undergraduate teaching hospitals normally have higher ratios of junior to senior medical staff than are to be found in other district general hospitals and senior staff are thus concerned with teaching and training at several levels. Training requirements have been set out clearly for each discipline and the Council for Postgraduate Medical Education has been examining programmes of training and criteria for the approval of posts. Machinery has been developed to take account of the needs of individual junior doctors and vocational arrangements for those wishing to enter general practice are developing. Some teaching hospitals, notably those in London, lack a postgraduate medical institute. District general hospitals, including undergraduate teaching hospitals with full district responsibilities, are natural focal points for postgraduate medical education. They should all have postgraduate medical institutes as the common meeting ground for general practitioners and junior and senior medical staff.

Junior medical staff

99. The second Cogwheel report included a full discussion of the role of junior medical staff in the Cogwheel system and recommended that junior medical staff should have the opportunity to play a full part, through representatives, on divisions and medical executive committees. The evidence we have is that where junior medical staff are given this opportunity and encouraged to make full use of it the optimism of the second Cogwheel report about the value of the contribution they can make is amply justified. We have heard of particular problems encountered by junior medical staff—for example, in choosing the right representatives to sit on divisions and medical executive committees, in keeping representatives in touch with the views of junior medical staff so that they may contribute authoritatively to Cogwheel discussions about the organisation of their own work, and in arranging “deputies” for representatives prevented by clinical work from attending some Cogwheel meetings. These are mostly matters for junior medical staff to sort out for themselves. Experience of doing so will be valuable, for senior medical staff encounter similar difficulties. What is important is that junior medical staff should be given the opportunity to participate fully in the Cogwheel system, and that reasonable arrangements they make to secure this (for example, deputising schemes) should be accepted by divisions and medical executive committees.

Information services

100. The first Cogwheel report defined the sort of problems which divisions should keep under review—use of resources, organisation of services, review of clinical practice—and went on to say: “Obviously it is essential that the division

be supplied with data relevant to these functions—such as statistical information on admissions and discharges, waiting-lists, out-patient waiting times, and autopsy findings. Regular meetings of the division should be presented with information of this nature” (paragraph 61). Experience over the next four years led the Working Party to modify this guidance in two important respects. The second Cogwheel report recognised that a more sophisticated approach was required: “A regular study of statistics not only on bed use and waiting lists, but also relating to such matters as variations in treatment patterns, incidence of post-operative complications, re-attendance rate at out-patient clinics, can draw attention to matters needing further investigation that should be discussed in divisions” (paragraph 8.20). But the report also put forward the view that “there is little to be gained in presenting information to doctors unless it is acknowledged to be related to their needs, accurate, and presented as simply and clearly as possible. It is probably better to defer the routine presentation of information to doctors until these standards can be met” (paragraph 6.8). The report gave a number of specific examples (in Chapter 8) of the way in which divisions had tackled particular problems with the aid of information, and observed that the resulting improvements in patients services “were brought about by clinicians working together to define problems and apply relevant information to their analysis and their solution”.

101. In preparing this third report the Working Party has given a good deal of attention to the information needs of Cogwheel. The previous chapter, “Effective care”, has focussed on studies and surveys, based on controlled clinical trials and other research, which concentrate on the development of good medical practice and provide information capable of use in other clinical situations. We have also discussed some of the problems connected with the maintenance of medical records, in particular the development and use of problem-oriented medical records,* and possibilities of rationalising patients’ records so as to improve communication in medical care and meet the need for information in planning, management and research. These are subjects that should be discussed in divisions, together with representatives of nursing services and the administration.

102. The Working Party sponsored a symposium on information services for Cogwheel, at which a number of “efficiency” problems in the organisation of medical work—tackled with the aid of information available in most hospital groups—were reported and discussed. Members of the Working Party and others who participated in the symposium found it stimulating and valuable. We think that its proceedings will be of interest to many doctors, administrators and others concerned with divisional problems, and we have proposed that these should be published in an edited version.† This covers problems tackled

* McIntyre, N., Day, R. C., Pearson, A. J. G., *Can we write better notes? British Journal of Hospital Medicine*, May 1972.

† The report will be published by the Department of Health and Social Security during 1974 and sent to all health authorities, and to Chairmen of Medical Executive Committees, District Community Physicians, and District Administrators. A limited number of *individual* copies will be available on application to Health Services 1 Division Department of Health & Social Security, Alexander Fleming House, Elephant and Castle, London, S.E.1.

successfully with the use of information, gives examples of experiments in marshalling and presenting information, and illustrates the prerequisites of a successful information service.

103. The symposium provided ample support for the general approach—summarised above—of the second Cogwheel report to the development of information services. It showed that suitable administrative support must be available—the initiative for more than half the studies reported on at the symposium came partly (in some cases wholly) from administrators. It also brought out that administrative support and information services, however good, will be of no avail, unless medical staff themselves acknowledge that there is a problem worth tackling—or that they want and will use routine information to highlight possible problem areas—and are prepared to implement changes shown to be needed. Many kinds of information about use of resources are available locally* and could be deployed in pursuit of greater efficiency in the organisation of medical work. When “problems” are perceived as such and there is a will to tackle them as well as commitment to implement solutions, information can be used to great effect.

* A useful summary of what is available and its strength and weaknesses is set out in *Cogstats*, King Edwards Hospital Fund for London, 1974.

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